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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JAMIE DIANE MONKS** **2901 Sillect Ave, Suite 202** **Bakersfield, CA 93308** **Registered Nurse License No. 534540** Respondent.	Case No. 2010-148 **ACCUSATION**

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 29, 1997, the Board of Registered Nursing (Board) issued Registered Nursing License No. 534540 to Jamie Diane Monks (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein. It expired on August 31, 2009, and has not been renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

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COST RECOVERY

8. Section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL SUMMARY

9. In or about May, 2003, Respondent was employed as a registered nurse at Western Pacific Oncology, in Bakersfield, CA (Western Pacific). Respondent worked in the intravenous (IV) fusion clinic, administering chemotherapy and other medications.

10. Patient Enrique P. (E.P.), a 38 year old male was diagnosed with multiple myeloma.

11. On or about May 13, 2003, E.P. was seen by Dr. Herbert Rappaport at Western Pacific Oncology. To provide for the proper delivery of certain chemotherapy drugs, Dr. Rappaport ordered the surgical installation of a Port-A-Cath (a subcutaneous drug-administration device that drugs into a large vein) for him.

12. On or about May 22, 2003, E.P presented himself to Respondent at Western Pacific Oncology with a prescription from Dr. Rappaport for the monthly IV administration of the medication Zometá4. Respondent administered the Zometa intravenously, as provided for in the prescription. E.P. tolerated the Zometa well, and following the IV-administration, all of his vital signs were stable. Respondent then instructed E.P. to return in one month for his next infusion.

13. On or about May 27, 2003, E.P. had the Port-A-Cath ordered by Dr. Rappaport surgically installed.

14. On or about May 29, 2003, E.P. again presented himself to Respondent for the administration of chemotherapy, this time with an order for delivery through the Port-a-Cath that had just been surgically inserted. Respondent noticed the Port-a-Cath, and attempted to access it in order to administer the chemotherapy medication, but E.P. stated that he did not want the drugs delivered through the Port-a-Cath because it was too painful.

15. Respondent called Dr. Rappaport to obtain an order for IV-administration instead, but did not reach him.

16. Respondent made a unilateral decision herself to change the administration route to administer the chemotherapy intravenously, rather than by the Port-a-Cath delivery route provided for in Dr. Rappaport's order.

17. Respondent administered the chemotherapy through a four-day IV-infusion.

18. E.P. initially tolerated the chemotherapy well, and was instructed to call Dr. Rappaport to report any fever or side effects.

19. In the patient care notes for E.P. for May 29, 2003, Respondent failed to document the medication contained in the four day infusion.

20. Later that evening on May 29, 2003, E.P. began to feel pain and noticed a rash on his arm. The rash resulted from the infiltration (leaking into the surrounding tissue) of some of the chemotherapy medication Respondent had administered earlier that day.

21. The following day, on or about May 30, 2003, E.P. and his wife called Dr. Rappaport to report the pain and rash that had accompanied the IV-administration of his chemotherapy. Dr. Rappaport only then learned that the chemotherapy medication had been administered intravenously. He advised E.P. to discontinue using the IV-pump and to go to the emergency room immediately.

22. On or about May 31, 2003, E.P. was admitted to Bakersfield Memorial Hospital, in Bakersfield, California, complaining of pain, swelling, and redness around the right wrist. E.P. was diagnosed with cellulitis of the right wrist with extravasation of the chemotherapeutic agents Vincristine and Doxorubicin (Adriamycin) and had a temperature of 101. E.P. was in the hospital for four days and required subsequent surgery to repair the tissues damaged in his right hand.

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CAUSE FOR DISCIPLINE

(Gross Negligence)

23. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for gross negligence, as defined in California Code of Regulations, title 16, section 1442, in that Respondent was grossly negligent in her care of patient E. P. for the reasons stated in paragraphs 9 through 16 above and for the following reasons:

a. Respondent jeopardized E.P.'s life and her actions represented an extreme departure from the standard of care when she administered chemotherapy to patient E.P. without any specialized training regarding the administration and care of a patient receiving chemotherapeutic agents. By her own admission, Respondent agreed to work at Western Pacific Oncology with complete awareness of her total lack of experience and knowledge of chemotherapy administration. Although Respondent had requested training from Western Pacific Oncology, none was provided, and Respondent made no other efforts to gain relevant knowledge of chemotherapy agents and their proper administration. Instead, she proceeded untrained to perform chemotherapy administration.

b. Respondent jeopardized E.P.'s life and her actions represented an extreme departure from the standard of care when she disregarded the physician's order regarding the proper route to be used for the administration of chemotherapy to patient E.P. on May 29, 2003. Respondent unilaterally decided to proceed with the IV- chemotherapy administration that E.P. had requested without physician order authorization for this route. Respondent erroneously concluded that if it had been acceptable to administer the medication Zometa intravenously on May 22, 2003, then it would also be acceptable to administer Vincristine and Doxorubicin (Adriamycin) intravenously on May 29, 2003.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Registered Nursing License No. 534540, issued to Respondent.

2. Ordering Respondent to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to section 125.3.

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/24/09

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant